

## NEWS RELEASE

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### **Statutory review needed for all drowning fatalities in Scotland, recommends WSS**

Water Safety Scotland (WSS) has published a new report entitled Preventing Future Fatalities – Improving Water-Related Fatality Data in Scotland. The report, completed by the WSS Data Subgroup and chaired by the Royal Society for the Prevention of Accidents (RoSPA), looks at the current legal landscape around accidental water related fatalities in Scotland.

The report forms a key part of Scotland's Drowning Prevention Strategy which looks to reduce accidental drowning deaths in Scotland by 50 per cent by 2026 and reduce risk among the highest-risk populations, groups and communities. [www.watersafetyscotland.org.uk/media/1213/scotlands-drowning-prevention-strategy.pdf](http://www.watersafetyscotland.org.uk/media/1213/scotlands-drowning-prevention-strategy.pdf)

In Scotland, there is currently no formal requirement for a systematic review of accidental drowning fatalities. The main law, The Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016, places a mandatory duty to investigate a fatality if it happened in employment, legal custody or was a child in secure accommodation. This means that all other accidental fatalities such as drowning are discretionary.

Three options are suggested by Water Safety Scotland to improve fatality data and ensure a consistent approach:

- An amendment to the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016, or
- The introduction of a statutory review process, similar to the Child Death Review process, or
- A voluntary review process.

The WSS Data Subgroup includes RNLI, Scottish Canals, family representatives, and community safety development manager for RoSPA, Carlene McAvoy, led the report as chair of group. Carlene said: "We compared the Scottish law with other countries such as England and Wales where the process is different and unintentional fatalities are mandatory to investigate. The fatalities report draws on the benefits of inquests and both a family perspective and rescue workers' experience."

Family representative for the WSS Data Subgroup, Gillian Barclay, said: "For families who have lost a loved one in a drowning accident the overriding reaction, after the shock, is that this tragedy should never happen to anyone else. It is therefore really important that lessons are learnt from every accidental drowning. For me personally, I needed to know what happened to my son the day he

drowned and I know that many other parents and loved ones also want to understand what went wrong and what could have been prevented.”

The Royal College of Paediatrics and Child Health (RCPCH) also support the document. Its officer for Scotland, Professor Steve Turner, said: “Every death of a child and young person is a tragedy, but we can learn from these events. We need a national system which ensures that the necessary level of information is obtained from the death of every child up to the age of 26.

“The April 2020 launch of the National Hub for Reviewing and Learning from the Deaths of Children and Young People provides the opportunity to prioritise the creation of a system to identify why all these tragedies occur and to take appropriate action to prevent them in future.”

This report features in the WSS two-year review of the strategy which will be launched at RoSPA’s Water Safety Conference on Thursday, March 26. For a copy of the report contact [cmcavoy@rospa.com](mailto:cmcavoy@rospa.com)

**ENDS**

WSS aims to reduce the number of accidental drowning deaths in Scotland by 2026. Find out more at [www.watersafetyscotland.org.uk](http://www.watersafetyscotland.org.uk) and [Scottish Drowning Prevention Strategy](#).